Table 12. Best Practice Recommendations for Regional Anesthesia[3,157,167-175]

Best Practice Recommendations for Regional Anesthesia
Do not avoid or delay epidural anesthesia as a method of reducing risk for cesarean delivery
In the absence of a medical contraindication, if a woman specifically requests pain relief by epidural anesthesia, there is no need to wait for a minimum or arbitrary cervical dilation before administering (maternal request is a sufficient indication to provide pain relief through regional anesthesia)
The woman should be assisted in changing position at least every 20 minutes to assist necessary fetal rotation
Allow for longer durations of the second stage for women with regional anesthesia (e.g. at least 4 hours in nulliparous women, at least 3 hours in multiparous women), as long as maternal and fetal statuses remain reassuring
Allow for passive descent when there is no urge to push (delayed pushing until there is a stronger urge to push, generally 1-2 hours after complete dilation). Passive descent is correlated with shorter overall pushing time and greater chance of spontaneous vaginal birth
Preserve as much motor function as possible by administering the lowest concentration of epidural local anesthetic necessary to provide adequate maternal pain relief. Epidural solutions containing opioids allow less local anesthetic use without compromising labor analgesia
Turning an epidural off during the second stage of labor to improve pushing efforts is rarely necessary and likely has minimal beneficial effect on the length of the second stage
Utilize patient-controlled epidural anesthesia (PCEA) with background maintenance infusion that is intermittent or continuous (for laboring women, this is superior to PCEA alone and continuous infusion epidural)